

Prelaparoscopy patient history checklist

Past medical history

- ☐ Enumeration of each prior abdominal/pelvic surgical procedure and the underlying etiology (e.g., peritonitis secondary to a ruptured appendix)
- ☐ Abdominal radiation: reason and exact placement of the radiation therapy portals
- ☐ Intra-abdominal or pelvic inflammation or infection (e.g., generalized peritonitis, cholecystitis, diverticulitis, endometriosis, peptic ulcer disease, pelvic inflammatory disease)
- ☐ Hip prosthesis (retroperitoneal leakage of prosthetic glue may result in extreme pelvic fibrosis)
- ☐ Other prosthetic or cardiac problems indicating a need for subacute bacterial endocarditis prevention
- ☐ Prior deep venous thrombosis or history of thromboembolic disorders

Risk factors for general anesthesia

- ☐ Significant pulmonary or cardiac disease
- ☐ Prior anesthetic problems
- ☐ Hypertension (? controlled)

Medications

- ☐ Steroids
- ☐ Pulmonary medications
- ☐ Cardiac medications
- ☐ Anticoagulants or agents with an anticoagulant effect (e.g., aspirin, non-steroidal anti-inflammatory agents)

Allergies

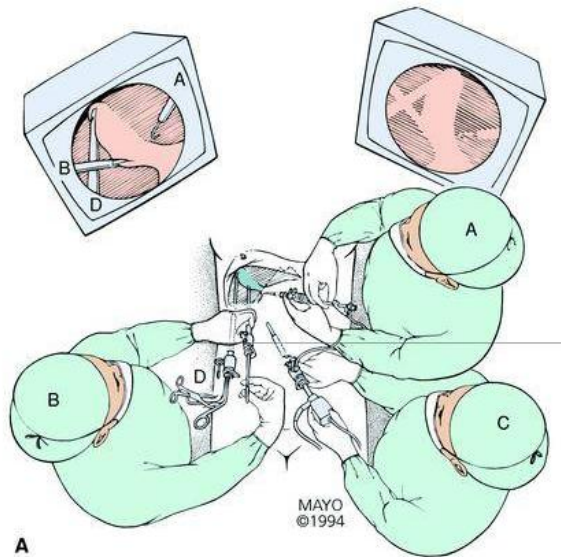
- ☐ Medications (including local anesthetics)
- ☐ Skin preparations (e.g., Betadine)

LAPAROSCOPY IN GENERAL

dratef.net

Pre laparoscopy Examination

We put well prepared patient in supine position, after general endotracheal anesthesia, giving peri-operative antibiotics (Gentamicine 80mg- +Cefataxime 1000mg): e do the laparoscopy as following;



Prelaparoscopy physical examination

General

- ☐ Blood pressure: rule out uncontrolled hypertension
- ☐ Temperature: rule out sepsis
- ☐ Pulse: rule out uncorrected cardiac dysrhythmias

Chest and cardiac examination

- ☐ Routine examination to determine suitability for a general anesthetic

Abdominal and pelvic examination

Inspection

- ☐ Site of prior incisions
- ☐ Umbilical abnormalities
- ☐ Umbilical hernia
- ☐ Incisional hernia

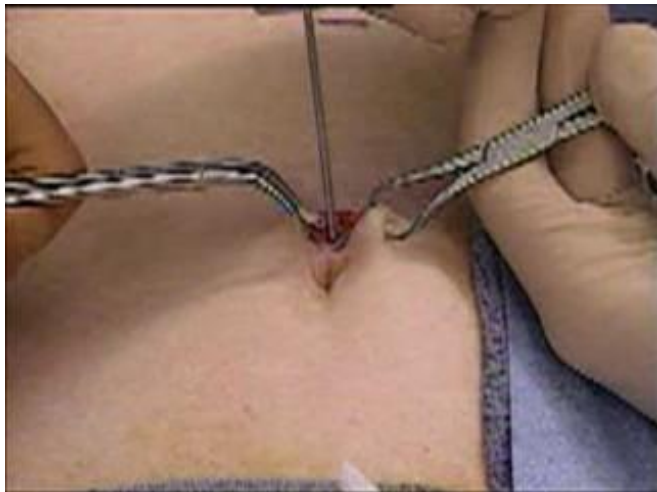
Palpation

- ☐ Intra-abdominal mass
- ☐ Abdominal tenderness: localized, general/deep, or rebound
- ☐ Umbilical hernia
- ☐ Incisional hernia
- ☐ Widened aortic pulsation (rule out abdominal aortic aneurysm)
- ☐ Fixed or frozen pelvis on vaginal/rectal examination

Auscultation

- ☐ Bruits indicative of aortic or iliac/femoral artery aneurysms
- ☐ Bowel sounds (rule out obstruction)

entered peritoneal cavity, 10cc syringe with 5 cc of saline is connected to the Veress needle, aspirate, and inject the saline then aspirate, no fluid will be aspirated.



Insertion of Veress needle

Once we are sure that the tip is in the peritoneal cavity, needle connected to the CO₂ tube.



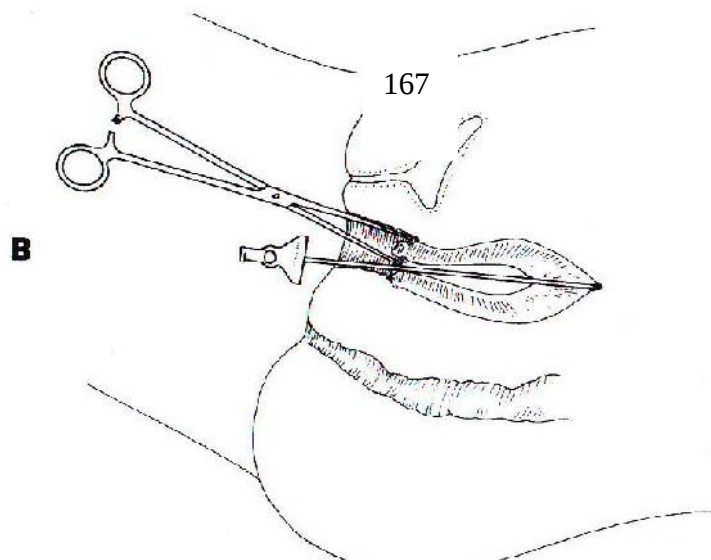
Operative room setup for Laparoscopy in general

- * On table shaving and Disinfection of the field of the surgery
- * Draping
- * Nasogastric tube (for not fully fasting patient: emergency and in upper abdominal procedures) will be inserted
- * Urinary catheter in lower abdominal procedures
- * Pneumoperitonium



Small incision for insertion of Veress needle

Tiny stab incision by No.12 blade below or above or via umbilicus, 14-gauge or 2mm in diameter (6 Fr) Veress needle pressed in the wound 45 degree caudal, in obese patients press perpendicularly. As the needle



Insertion of Veress needle Through Uterus

POSITIONING

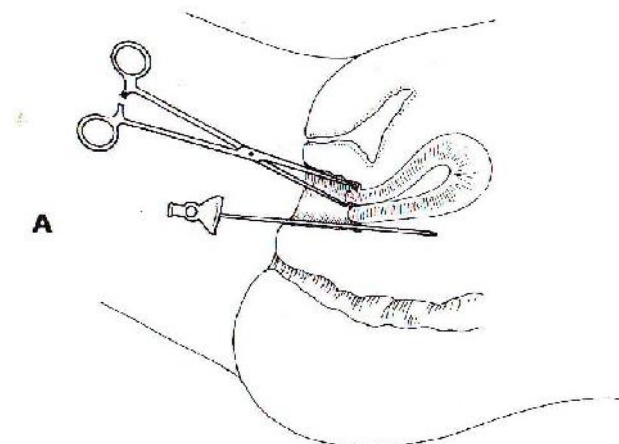
According to the procedure, the patient is put in different position, for example: head up and turning the table to left. For Appendectomy head down and turning the table to left...etc.

TROCARS;

The flow must be set to less than one liter per minute. and initially the intraabdominal pressure must be less than 10mm Hg, then the flow set to 6L/min, till the intraabdominal pressure become 15mmHg , this means approximately 3-6L of CO₂ have been instilled into peritoneal cavity

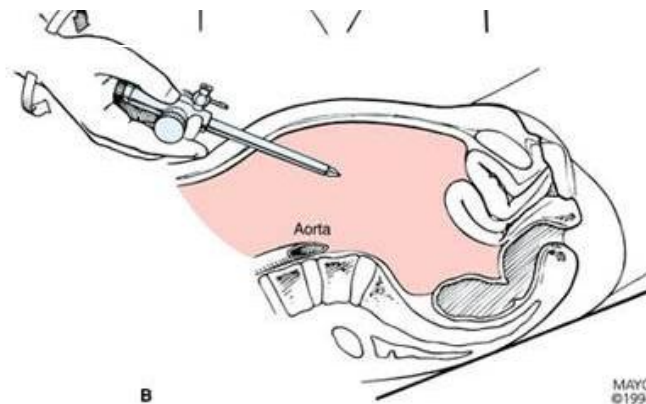
Alternatives;

In selected female patients ,instillation done by passing the needle via posterior fornix of vagina, in the midline to depth of 3 cm, which both safe and effective .



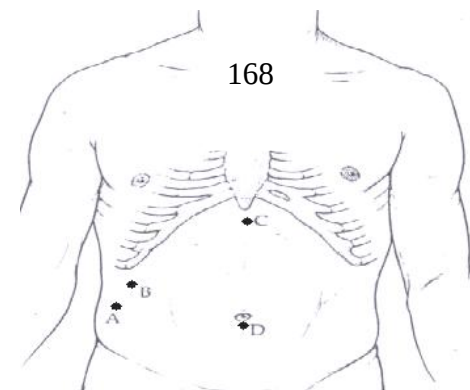
Insertion of Veress needle Through Fornix

Insertion of the first trocar



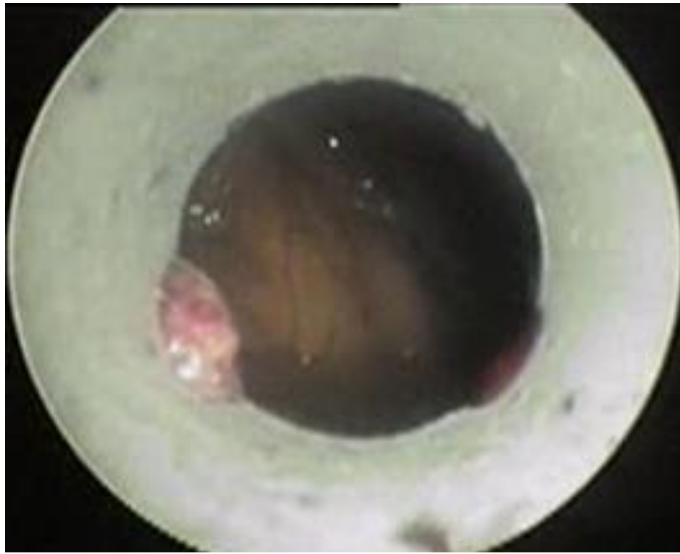
Then obturator of the trocar removed

Number and site of the trocars are different according to the type of the operation i.e.

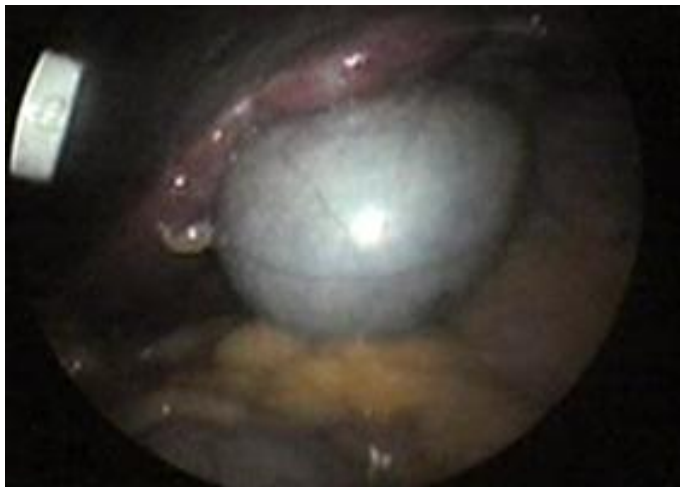


For laparoscopic cholecystectomy we put 4 trocars ,first above umbilicus via 1cm incision





Inside view of the trocar



And the side of the trocar connecting with the insufflators



Now we introduce the telescope via the sheath first trocar



Insertion of the telescope via first trocar

side arm for CO₂ insufflation, while others put under direct vision as long as we introduced the laparoscope via first trocar

The angle of insertion of periumbilical trocar is 90 degrees at the start, once the tip of the obturator passed skin and subcutaneous fat; it must be tilted to 60-70 degrees angle, It is better to direct all the port toward the site of the operation

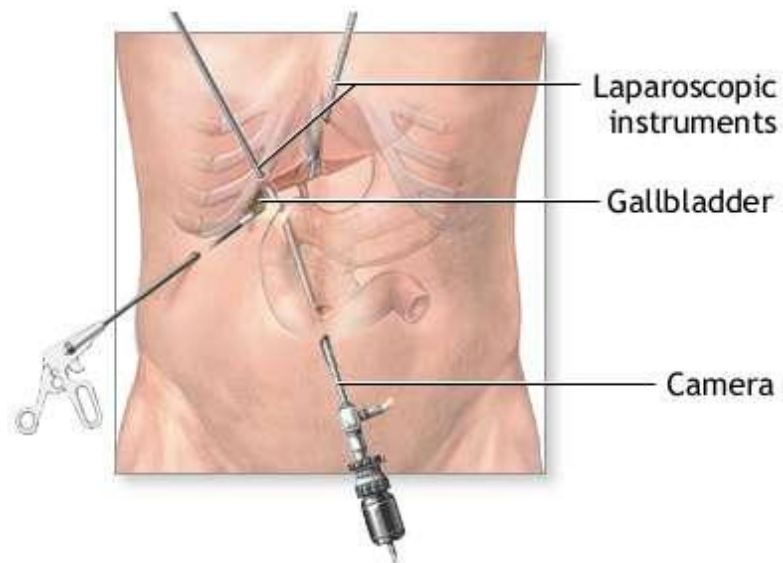
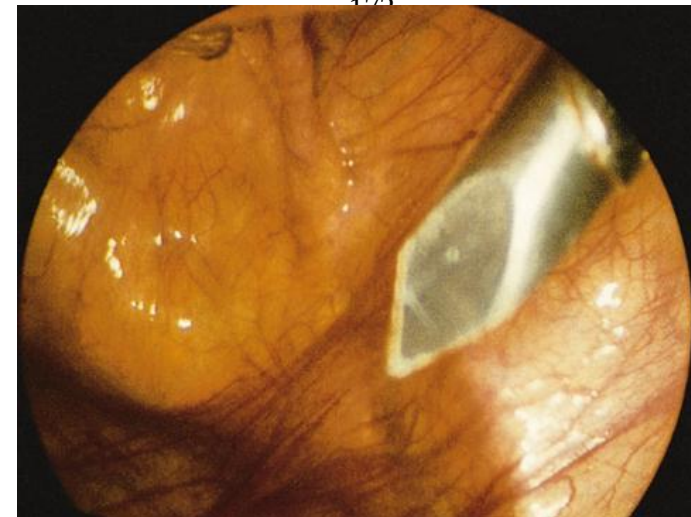


Diagram showing all the trocars in place

View of the liver and gallbladder

Second trocar put via 10mm incision at point in the midline 6cm below xiphisternum,



Insertion of 2nd trocar under direct vision

Third trocar put just below costal margin at right midclavicular line, fourth at midaxillary line at level of umbilicus. 3rd & 4th trocars are 5mm without sidearm for CO₂ insufflation. To avoid injury to any superficial abdominal wall vessels, the room light turned off, by help of the light of the scope the site transilluminated from inside the abdomen. First trocar is usually put blindly after obtaining pneumoperitonium which is 10mm in diameter with



Removal of the trocars under direct vision and inspecting the ports

POST_OPERATIVE CARE

- the patient ambulated within 2-3hours
- after 2 hours oral fluid started, regular meal allowed after 6 hours
- completion of peri-operative antibiotics
- non-opiate Analgesia (spasmolytic for biliary surgery)
- Send home in few hour when fulfilling criteria of daycare discharge

Hasson open cannula insertion;

A transverse periumbilical incision made 2cm in length, under direct vision deepened to peritoneum, which must be grasped by hemostats and opened , then 0 absorbable suture placed on either side of the incised fascia and the trocar inserted .this give opportunity for faster pneumoperitonium.

FORMAL LAPAROSCOPY

After confirmation of right insertion of the rest of the trocars, we examine the viscera systematically, first lower abdomen then upper abdomen.

Exiting of the abdomen

At the en of the operation, second look of the surgical field is mandatory to find any bleeding or injuries, then intraabdominal pressure lowered to 5mmhg to allow any bleeding from injured veins .Now the peritoneum, particularly site of the operation irrigated by 500 to 2000cc of fluid, we examined area again for any features of injury and aspirate as much as possible from irrigated fluid

Withdrawal of the sheath of the trocars

We usually inspect the site of the trocars and withdraw them under direct vision , the last of the scope port withdrawn slowly with the telescope. The fascial defect of 10mm trocar not needs closure, on theoretical grounds alone we cannot see the closure of 1 cm defect

<http://dratef.net/>

<http://dratefahmed.blogspot.com/>

<http://medical.shoppingdealer.com/>

<http://tv.dratef.net/>

<http://books.dratef.net/>

<http://feeds.feedburner.com/Dratefnet>

<https://www.facebook.com/onlinemedicalbook/>

<https://www.facebook.com/onlineSurgicalbook/>

<https://twitter.com/DrATEFAHMED>

<https://twitter.com/medicalbook1>

<https://www.instagram.com/dr.atefahmed/>

<https://www.linkedin.com/in/dratef/>

<https://www.pinterest.com/shoppingdealer2/>

<http://feeds.feedburner.com/semnatv/wxHK>

<http://shoppingdealer.com/>

<http://ymarryme.com/>

<http://semnatv.com/>